DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners
- Ophthalmologists
- Psychiatrists
- Emergency Physicians
- Nurse Anesthetists
- Physicians
- Physician Clinics
- Registered Nurse First Assistants
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Plans
- Podiatrists
- Radiologists
- Regional Administrators
- CSO Administrators

Memorandum No: 02-75 MAA
Issued:

For Information Call:
1-800-562-6188

Related Memo: 02-32 MAA

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **Corrected Replacement Pages for MAA's Physician-Related Services (RBRVS) Billing Instructions**

Attached to this memorandum are two corrected replacement pages (H9/H10 and O3/O4) for the Medical Assistance Administration's (MAA) Physician-Related Services Billing Instructions.

Two of the replacement pages sent to providers on July 17, 2002, under Numbered Memorandum 02-32 MAA were printed incorrectly.

- Page H8 was printed twice; page H9 was missing; and
- On page O3/O4, the "YR" and "NR" requirements under field 24E (EPSDT) on the HCFA-1500 claim form were inadvertently left in. These requirements no longer apply and have been removed.

SAMPLE B: Amended

Washington State Department of Social & Health Services

CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

• CONSENT TO STERILIZATION •

I have asked for and received information about sterilization from _____.
DOCTOR OR CLINIC

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____.
MONTH DAY YEAR

I, (4) Jane Doe, hereby consent of my own free will to be sterilized by (5) Dr. Mary Williams.
DOCTOR

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) Jane Doe _____ Date: 10/01/01
SIGNATURE MONTH DAY YEAR

You are requested to supply the following information, but it is not required. **RACE AND ETHNICITY DESIGNATION (PLEASE CHECK):**

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

• INTERPRETER'S STATEMENT •

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
INTERPRETER DATE

• STATEMENT OF PERSON OBTAINING CONSENT •

Before _____ signed the consent
NAME OF INDIVIDUAL
form, I explained to him/her the nature of the sterilization operation

STATEMENT OF PERSON OBTAINING CONSENT (CONTINUED):

_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ Date: _____
SIGNATURE OF PERSON OBTAINING CONSENT

_____
FACILITY

_____
ADDRESS

• PHYSICIAN'S STATEMENT •

Shortly before I performed a sterilization operation upon (13) Jane Doe on
NAME: INDIVIDUAL TO BE STERILIZED
(14) 10/01/01, I explained to him/her the nature of
DATE: STERILIZATION OPERATION
the sterilization operation (15) tubal ligation, the fact that
SPECIFY TYPE OF OPERATION
it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(INSTRUCTIONS FOR USE OF ALTERNATIVE FINAL PARAGRAPHS: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1. At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

2. This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery (describe circumstances):

(16) Mary Williams MD . 10/01/01
PHYSICIAN DATE

DSHS 13-364 (X) (REV. 06/1997)

NOTICE: ALL BLANKS MUST BE COMPLETED EXCEPT AS INDICATED BELOW

Instructions to the Patient for Completing Consent to Sterilization

1. In the first blank space, write the name of the doctor or clinic giving you the information.
2. In the second blank space, write the name of the operation.
3. In the next blank space, you must write the month, day, and year you were born.
4. Fill in the last five blanks as indicated. Be sure the doctor's name is the name of the physician who will actually perform the operation.
5. You are not required to fill out the "Race and Ethnicity" portion. It is optional.

Interpreter's Statement

This section of the form should be completed ONLY if interpretation into another language is required.

Statement of Person Obtaining Consent

1. Complete the first two blanks with the patient's name and the name of the procedure to be performed.
2. Fill in the last four blanks with your signature, date, name, and address of the facility.

Physician's Statement

1. Complete the first three blanks with the name of the individual to be sterilized, the date of the sterilization operation, and the specific type of operation.
2. Cross out the "alternative final paragraph" if inappropriate.
3. The performing surgeon must sign. The date given below the signature must either be the date of the sterilization or a date which follows the sterilization.
4. The performing surgeon's name must appear in the ***sterilized by*** blank in the CONSENT TO STERILIZATION section.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, EPSDT, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her Social Security Number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?**: Indicate *yes* or *no*. If yes, you should have completed *fields 9a. – d*.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved For Local Use**: When applicable, enter indicator **B**, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report).

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., August 4, 2002 = 080402).

24B. **Place of Service**: Required. See pages J2 and J3 for correct POS codes. These are the only appropriate place of service codes:

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charges for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

24H. **EPSDT Family Plan**: When billing the department for one of the EPSDT screening procedure codes, enter an **X** in this field.

25. **Federal Tax I.D. Number: Leave this field blank.**